STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175537	A. BUILDING _____ B. WING _____	07/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYS MEDICAL CENTER LTCU	2220 SW CANTERBURY DRIVE HAYS, KS 67601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility had a census of 4 residents. The sample included 4 residents who were reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to ensure 4 of the sampled resident's drug regimen were free from unnecessary drug use. (#56, #57, #10, #55)	F 329		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 329	Continued From page 1 Findings included: - Resident #56's 5 day (MDS) Minimum Data Set assessment, dated 7/19/15, indicated the resident had intact cognition, required limited assistance of 1 staff with bed mobility, transfer, walking in corridor, dressing, toilet use and supervision with personal hygiene. The MDS further indicated the resident had an unsteady balance, used a walker and wheelchair, received (PRN) as needed pain medication, insulin injections, and antibiotic medications. The 7/15/15 care plan directed the staff to monitor the medications for side effects. The care plan lacked direction for monitoring of the resident for adverse consequences associated with the administration of medications with black box warnings. The 7/14/15 physician's orders directed the staff to administer to the resident, the following medications. Further review revealed the physician ordered medications had (BBW) Black Box Warnings: 1) Metformin Hydrochloride (a diabetes medication), 1000 (mg) milligrams, orally, twice daily, initiated 7/13/15. According to the (FDA) Food and Drug Administration, MedWatch, dated 8/27/2008, a black box warning was identified for lactic acidosis (low pH in body tissues and blood) which is a rare, but serious, metabolic complication that can occur due to Metformin accumulation during treatment.	F 329		

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F 329	Continued From page 2	F 329		

2) Lopressor (a blood pressure medication), 75 mg, orally, once daily, initiated 7/13/15.

According to the FDA, MedWatch, dated 12/21/12, a black box warning was identified for ischemic heart disease (reduced blood supply to the heart).

3) Oxycodone Hydrochloride(a narcotic pain medication), 5-10 mg, orally, every 4 hours, (PRN) as needed, initiated 7/13/15.

According to the FDA, MedWatch, dated 1/8/10, a black box warning was identified for respiratory depression.

4) Tylenol (acetaminophen), 325-650 mg, orally, every 4 hours, PRN, initiated 7/13/15.

According to the FDA, MedWatch, dated 1/13/11, a black box warning was identified for the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth and throat, difficulty breathing, itching or rash) will be added to the label of all prescription drug products that contain acetaminophen...Advise patients not to exceed the acetaminophen maximum total daily dose (4 grams/day) = 4000 milligrams.

On 7/22/15 at 8:15 AM, observation revealed Resident #56, seated on the edge of his/her bed, and staff administering morning medications to him/her.

On 7/22/15 at 2:58 PM, Administrative Nurse A verified the resident did not have an individualized care plan instructing the staff to monitor for

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F 329	Continued From page 3 adverse consequences associated with the administration of BBW medications. Administrative Nurse A stated the facility does not have a system for care planning of BBW medications. Although requested, the facility did not provide a policy for the care planning of the BBW medications. The facility failed to identify and monitor Resident #56 for the adverse consequences associated with the potential administration of these medications with black box warnings. - The facility admitted Resident #57 on 7/20/15, and indicated the resident was alert and oriented, required assistance with ambulation, normal upper extremity strength normal, lower extremities with mild weakness, and skin intact. The 7/21/15 care plan lacked direction to staff for monitoring of the resident for adverse consequences associated with the administration of medications with black box warnings. The 7/21/15 physician's orders directed the staff to administer to the resident, the following medications. Further review revealed the physician ordered medications had (BBW) Black Box Warnings: 1) Lopressor (a blood pressure medication), 25 mg, orally, twice daily, initiated 7/20/15. According to the FDA, MedWatch, dated 12/21/12, a black box warning was identified for	F 329		

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F 329	Continued From page 4 ischemic heart disease (reduced blood supply to the heart). 2) Acetaminophen, 650 mg, every 4 hours, (PRN), as needed, initiated 7/14/15. According to the FDA, MedWatch, dated 1/13/11, a black box warning was identified for the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth and throat, difficulty breathing, itching or rash) will be added to the label of all prescription drug products that contain acetaminophen...Advise patients not to exceed the acetaminophen maximum total daily dose (4 grams/day) = 4000 milligrams. On 7/22/15 at 8:33 AM, observation revealed Resident #57, lying in his/her bed, and staff administering morning medications to him/her. On 7/22/15 at 2:58 PM, Administrative Nurse A verified the resident did not have an individualized care plan instructing the staff to monitor for adverse consequences associated with the administration of BBW medications. Administrative Nurse A stated the facility does not have a system for care planning of BBW medications. Although requested, the facility did not provide a policy for the care planning of the BBW medications. The facility failed to identify and monitor Resident #57 for the adverse consequences associated with the potential administration of these medications with black box warnings. - Resident #10's 5 Day (MDS) Minimum Data Set	F 329		

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assessment, dated 7/13/15, indicated the resident had intact cognition, required extensive assistance of 1 staff with most (ADLs) Activities of Daily Living, and had an unsteady balance. The MDS further indicated the resident received anticoagulant (blood thinning medication) and antipsychotic (medication to treat mental illness) medications.

The 7/13/15 Psychotropic drug use (CAA) Care Area Assessment stated Resident #10 received an antipsychotic medication each night for anxiety, and he/she stayed awake a portion of the night.

The 7/13/15 care plan lacked direction to staff for monitoring of the resident for adverse consequences associated with the administration of medications with black box warnings.

The 7/6/15 physician's orders directed the staff to administer to the resident, the following medications. Further review revealed the physician ordered medications had (BBW) Black Box Warnings:

*Lovenox (blood thinning medication), 40 (mg) milligrams, by mouth, every day, initiated 7/1/15.

According to www.fda.gov <http://www.fda.gov>, Lovenox (blood thinning medication) had a black box warning of spinal/epidural hematoma (collection of blood trapped in the tissues of the skin or in an organ), which may result in long-term or permanent paralysis.

*Risperdal (antipsychotic medication), 0.5 mg, by mouth, at bedtime, initiated 7/1/15.

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F 329	Continued From page 6 According to www.fda.gov <http://www.fda.gov>, Risperdal (antipsychotic medication) had a black box warning of increased mortality in elderly patients with dementia-related psychosis. *Tylenol (non-narcotic pain relief medication) 1000 mg, by mouth, every 6 hours, as needed for pain, initiated 7/4/15 and Norco (narcotic pain relief medication) 1 tablet, 5/325/ mg, by mouth, as needed for pain, initiated 7/10/15. According to the www.fda.gov <http://www.fda.gov>, Tylenol and Norco had a black box warning that identified the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth and throat, difficulty breathing, itching or rash). The 7/6/15 physician's order further lacked an appropriate diagnosis for the use of an anti-psychotic medication. On 7/22/15 at 8:25 AM, observation revealed Resident #10, seated upright in his/her recliner, covered with a blanket, with the bedside table and a full container of water in front of him/her. On 7/22/15 at 5:10 PM, Administrative Nurse A verified black box warnings should be listed on the care plans and the facility does not have a system for care planning of BBW medications. He/she stated the physician discontinued the administration of the anti-psychotic medication to the resident. Although requested, the facility did not provide a policy for the care planning of the BBW and	F 329		

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F 329	Continued From page 7 antipsychotic medications. The facility failed to identify and monitor Resident #10 for the adverse consequences associated with the potential administration of these medications with black box warnings and to ensure an appropriate diagnosis for the use of an antipsychotic medication. - Resident #55's 5 Day (MDS) Minimum Data Set assessment, dated 7/11/15, indicated the resident had intact cognition, required limited assistance of 1 staff with most (ADLs) Activities of Daily Living, and had an unsteady balance. The MDS further indicated the resident received anticoagulant medications. The 7/15/15 care plan lacked direction to staff for monitoring of the resident for adverse consequences associated with the administration of medications with black box warnings. The 7/11/15 physician's orders directed the staff to administer to the resident, the following medications. Further review revealed the physician ordered medications had (BBW) Black Box Warnings: *Xarelto (a blood thinning medication), 15 (mg) milligrams, orally, at hour of sleep, initiated on 7/11/15. According to the (FDA) Food and Drug Administration, MedWatch, dated 1/15/15, premature stopping of Xarelto increases the risk of blood clots. *Tylenol (acetaminophen), 650 mg, orally, every 4 hours (PRN) as needed, initiated 7/12/15.	F 329		

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F 329	Continued From page 8 According to the FDA, MedWatch, dated 1/13/11, a black box warning was identified for the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth and throat, difficulty breathing, itching or rash) will be added to the label of all prescription drug products that contain acetaminophen...Advise patients not to exceed the acetaminophen maximum total daily dose (4 grams/day) = 4000 milligrams. On 7/22/15 at 8:23 AM, observation revealed Resident #55, seated upright in his/her bed, eating breakfast independently. On 7/22/15 at 5:10 PM, Administrative Nurse A verified black box warnings should be listed on the care plans and the facility does not have a system for care planning of BBW medications. Although requested, the facility did not provide a policy for the care planning of the BBW medications. The facility failed to identify and monitor Resident #55 for the adverse consequences associated with the potential administration of these medications with black box warnings.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 334		

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F 334	Continued From page 9 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the	F 334		

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F 334	Continued From page 10 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This Requirement is not met as evidenced by: The facility had a census of 4 residents. The sample included 4 residents. Based on interview and record review, the facility failed to develop and implement policies and procedures related to influenza and pneumococcal immunizations. Findings included: - The facility's admission agreement, listed a standardized statement regarding provided treatments. The agreement lacked specific information for administration of the flu and pneumococcal immunization. On 7/22/15 at 4:35 PM, Nurse A verified the facility did not develop or implement policies and procedures for the immunization of the residents. The facility did not provide a policy and procedure for the influenza and pneumococcal immunizations. The facility failed to develop and implement policies and procedures related to influenza and pneumococcal immunizations.	F 334		

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F 428	Continued From page 11	F 428		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by: The facility had a census of 4 residents. The sample included 4 residents who were reviewed for unnecessary medications. Based on observation, record review and interview, the facility's consultant pharmacist failed to report to the director of nursing or the physician, the lack of monitoring of medications with Black Box Warnings for 4 of the sample residents. (#56, #57, #10, #55) Findings included: - Resident #56's 5 day (MDS) Minimum Data Set assessment, dated 7/19/15, indicated the resident had intact cognition, required limited assistance of 1 staff with bed mobility, transfer, walking in corridor, dressing, toilet use and supervision with personal hygiene. The MDS further indicated the resident had an unsteady balance, used a walker and wheelchair, received (PRN) as needed pain medication, insulin injections, and antibiotic medications. The 7/15/15 care plan directed the staff to	F 428		

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monitor the medications for side effects. The care plan lacked direction to staff for monitoring of the resident for adverse consequences associated with the administration of medications with black box warnings.

The 7/14/15 physician's orders directed the staff to administer to the resident, the following medications. Further review revealed the physician ordered medications had (BBW) Black Box Warnings:

1) Metformin Hydrochloride (a diabetes medication), 1000 (mg) milligrams, orally, twice daily, initiated 7/13/15.

According to the (FDA) Food and Drug Administration, MedWatch, dated 8/27/2008, a black box warning was identified for lactic acidosis (low pH in body tissues and blood) which is a rare, but serious, metabolic complication that can occur due to Metformin accumulation during treatment.

2) Lopressor (a blood pressure medication), 75 mg, orally, once daily, initiated 7/13/15.

According to the FDA, MedWatch, dated 12/21/12, a black box warning was identified for ischemic heart disease (reduced blood supply to the heart).

3) Oxycodone Hydrochloride(a narcotic pain medication), 5-10 mg, orally, every 4 hours, (PRN) as needed, initiated 7/13/15.
According to the FDA, MedWatch, dated 1/8/10, a black box warning was identified for respiratory depression.

4) Tylenol (acetaminophen), 325-650 mg, orally,

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every 4 hours, PRN, initiated 7/13/15.
According to the FDA, MedWatch, dated 1/13/11, a black box warning was identified for the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth and throat, difficulty breathing, itching or rash) will be added to the label of all prescription drug products that contain acetaminophen...Advise patients not to exceed the acetaminophen maximum total daily dose (4 grams/day) = 4000 milligrams.

Review of the consultant pharmacist review, dated 7/14/15, of Resident #56's medications revealed no documentation of the lack of monitoring of medications with Black Box Warnings

On 7/22/15 at 8:15 AM, observation revealed Resident #56, seated on the edge of his/her bed, and staff administering morning medications to him/her.

On 7/22/15 at 2:58 PM, Administrative Nurse A verified the facility's consultant pharmacist had not addressed the lack of monitoring of medications with Black Box Warnings.

The facility's consultant pharmacist failed to report to the director of nursing or the physician, the lack of monitoring of medications with Black Box Warnings for Resident #56.

- The facility admitted Resident #57 on 7/20/15, and indicated the resident was alert and oriented, required assistance with ambulation, normal upper extremity strength, lower extremities with mild weakness, and skin intact.

The 7/21/15 care plan lacked direction to staff for

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 14 monitoring of the resident for adverse consequences associated with the administration of medications with black box warnings. The 7/21/15 physician's orders directed the staff to administer to the resident, the following medications. Further review revealed the physician ordered medications had (BBW) Black Box Warnings: 1) Lopressor (a blood pressure medication), 25 mg, orally, twice daily, initiated 7/20/15. According to the FDA, MedWatch, dated 12/21/12, a black box warning was identified for ischemic heart disease (reduced blood supply to the heart). 2) Acetaminophen, 650 mg, every 4 hours, (PRN), as needed, initiated 7/14/15. According to the FDA, MedWatch, dated 1/13/11, a black box warning was identified for the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth and throat, difficulty breathing, itching or rash) will be added to the label of all prescription drug products that contain acetaminophen...Advise patients not to exceed the acetaminophen maximum total daily dose (4 grams/day) = 4000 milligrams. Review of the consultant pharmacist review, dated 7/21/15, of Resident #57's medications revealed no documentation of the lack of monitoring of medications with Black Box Warnings On 7/22/15 at 8:33 AM, observation revealed Resident #57, lying in his/her bed, and staff	F 428		

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F 428	Continued From page 15 administering morning medications to him/her. On 7/22/15 at 2:58 PM, Administrative Nurse A verified the facility's consultant pharmacist had not addressed the lack of monitoring of medications with Black Box Warnings. The facility's consultant pharmacist failed to report to the director of nursing or the physician, the lack of monitoring of medications with Black Box Warnings for Resident #57. - Resident #10's 5 Day (MDS) Minimum Data Set assessment, dated 7/13/15, indicated the resident had intact cognition, required extensive assistance of 1 staff with most (ADLs) Activities of Daily Living, and had an unsteady balance. The MDS further indicated the resident received anticoagulant (blood thinning medication) and antipsychotic (medication to treat mental illness) medications. The 7/13/15 Psychotropic drug use (CAA) Care Area Assessment stated Resident #10 received an antipsychotic medication each night for anxiety, and he/she stayed awake a portion of the night. The 7/13/15 care plan lacked direction to staff for monitoring of the resident for adverse consequences associated with the administration of medications with black box warnings. The 7/6/15 physician's orders directed the staff to administer to the resident, the following medications. Further review revealed the physician ordered medications had (BBW) Black Box Warnings:	F 428		

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F 428	Continued From page 16 *Lovenox (blood thinning medication), 40 (mg) milligrams, by mouth, every day, initiated 7/1/15. According to www.fda.gov <http://www.fda.gov>, Lovenox (blood thinning medication) had a black box warning of spinal/epidural hematoma (collection of blood trapped in the tissues of the skin or in an organ), which may result in long-term or permanent paralysis. *Risperdal (antipsychotic medication), 0.5 mg, by mouth, at bedtime, initiated 7/1/15. According to www.fda.gov <http://www.fda.gov>, Risperdal (antipsychotic medication) had a black box warning of increased mortality in elderly patients with dementia-related psychosis. The 7/6/15 physician's order further lacked an appropriate diagnosis for the use of an anti-psychotic medication. Review of the consultant pharmacist review, dated 7/6/15, of Resident #10's medications revealed no documentation of the lack of monitoring of medications with Black Box Warnings and did not identify the anti-psychotic medication required an appropriate diagnosis. On 7/22/15 at 8:25 AM, observation revealed Resident #10, seated upright in his/her recliner, covered with a blanket, with the bedside table and a full container of water in front of him/her.	F 428		

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On 7/22/15 at 2:58 PM, Administrative Nurse A verified the facility's consultant pharmacist had not addressed the lack of monitoring of medications with Black Box Warnings and the lack of an appropriate diagnosis for the antipsychotic medication.

The facility's consultant pharmacist failed to report to the director of nursing or the physician, the lack of monitoring of medications with Black Box Warnings and the lack of an appropriate diagnosis for the antipsychotic medication.

- Resident #55's 5 Day (MDS) Minimum Data Set assessment, dated 7/11/15, indicated the resident had intact cognition, required limited assistance of 1 staff with most (ADLs) Activities of Daily Living, and had an unsteady balance. The MDS further indicated the resident received anticoagulant medications.

The 7/15/15 care plan lacked direction to staff for monitoring of the resident for adverse consequences associated with the administration of medications with black box warnings.

The 7/11/15 physician's orders directed the staff to administer to the resident, the following medications. Further review revealed the physician ordered medications had (BBW) Black Box Warnings:

*Xarelto (a blood thinning medication), 15 (mg) milligrams, orally, at hour of sleep, initiated on 7/11/15.

According to the (FDA) Food and Drug Administration, MedWatch, dated 1/15/15, premature stopping of Xarelto increases the risk of blood clots.

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F 428	Continued From page 18 *Tylenol (acetaminophen), 650 mg, orally, every 4 hours (PRN) as needed, initiated 7/12/15. According to the FDA, MedWatch, dated 1/13/11, a black box warning was identified for the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth and throat, difficulty breathing, itching or rash) will be added to the label of all prescription drug products that contain acetaminophen...Advise patients not to exceed the acetaminophen maximum total daily dose (4 grams/day) = 4000 milligrams. Review of the consultant pharmacist review, dated 714/15, of Resident #55's medications revealed no documentation of the lack of monitoring of medications with Black Box Warnings On 7/22/15 at 8:23 AM, observation revealed Resident #55, seated upright in his/her bed, eating breakfast independently. On 7/22/15 at 2:58 PM, Administrative Nurse A verified the facility's consultant pharmacist had not addressed the lack of monitoring of medications with Black Box Warnings. The facility's consultant pharmacist failed to report to the director of nursing or the physician, the lack of monitoring of medications with Black Box Warnings for Resident #55.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		

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F 441	Continued From page 19 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility had a census of 4 residents. The sample included 4 residents. Based on observation, record review, and interview the facility failed to provide a sanitary environment to help prevent the development and transmission	F 441		

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of disease and infection, by improper cleaning of a resident's bathroom and associated nursing equipment for the 4 residents residing in the facility.

Findings included:

- On 7/21/15 at 8:20 AM observation of the interior of the microwave oven at the nurse's station revealed splattered grease and particles from food products. Further observation revealed, approximately 1/5 of the interior surface area remained clear of food spatters.

On 7/22/15 at 1:40 PM, observation revealed, Housekeeping Staff B entered Resident #56's and he/she put on gloves to prepare to clean the resident's bathroom. Housekeeping Staff B carried an uncovered, contaminated stool riser, bucket, and shower chair down the carpeted hallway to the soiled utility room where she/he opened the door with the soiled gloves on. Housekeeping Staff B returned to Resident #56's room and placed a bucket with 2 bottles of cleaner in it, on the bathroom floor. Housekeeping Staff B, used a toilet brush with a cloth head to clean the stool. He/she then removed the brush from the water in the stool bowl, placed the brush into the bucket with the 2 cleaning bottles and contaminated the bottles.

On 7/22/15 at 2:05 PM Housekeeping Staff B stated the facility staff carried the contaminated equipment, to the soiled utility room, from that point the equipment went to central sterilization to be thoroughly cleaned. Housekeeping Staff B stated staff used the same toilet bowl brush from room to room and exchanged the soiled brush for

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a new one every 1-2 days. Housekeeping Staff B acknowledged carrying the soiled equipment in the hallway, and the use of the same toilet bowl brush, placed in the bucket with the bottles of disinfectant and carried from room to room, increased the risk for contamination to other areas.

On 7/22/15 at 3:34 PM, Housekeeping Staff C verified the increased risk of contaminating other areas and/or equipment the residents may come in contact with, by carrying contaminated equipment down the hallway. Housekeeping Staff C verified the use of the same toilet bowl brush in the bucket with the soiled bottles of disinfectant, carried from room to room, created an infection control problem.

On 7/21/15 at 8:20 AM, Nurse D stated staff occasionally used the microwave to warm food for the resident's brought in by family members.

On 7/22/15 at 4:35 PM, Nurse A verified the staff did not clean the microwave as instructed and the microwave should be free of spatter.

The 7/12/2010 facility's Restroom Cleaning procedure, instructed staff to clean the bathroom from the top down, starting with the vents and ceiling, and to clean the toilet last. The procedure did not address transportation of contaminated equipment or the use of the toilet bowl brush and frequency of change.

The facility failed to provide a sanitary

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F 441	Continued From page 22 environment to help prevent the development and transmission of disease and infection, by improper cleaning of the microwave, and resident bathrooms.	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This Requirement is not met as evidenced by: The facility had a census of 4 residents. The sample included 4 residents. Based on interview and record review, the facility failed to maintain a (QAA) quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility,	F 520		

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F 520	Continued From page 23 and at least 3 other members of the facility's staff. Findings included: - The facility's QAA committee meeting attendance page revealed the committee met on the following months and the physician did not attend the meetings. (September 2014, December 2014, February 2015, May 2015) Review of the QAA committee meeting attendance revealed the physician did not attend the meetings in the 3rd and 4th quarters of 2014 and the 1st and 2nd quarters of 2015. On 7/22/15 at 4:35 PM, Nurse A verified the physician did not attend the QAA meetings on the above dates. Although requested the facility did not provide a policy and procedure for the QAA program or the QAA committee. The facility failed to ensure the quality assessment and assurance program maintained attendance by the required members of the committee.	F 520		